



City of Norfolk
Department of Neighborhood and Leisure Services
Therapeutic Recreation Center
Physician Referral and Information Form
(PLEASE PRINT CLEARLY)

Participant's Name _____

Participant's Desired Therapeutic Recreation Class (s) _____

Primary Diagnosis _____

Secondary Diagnosis _____

Additional History (may use back) _____

List Any Specific Movement, Positions, or Exercises To Be Encouraged:

List Any Contra-Indications (Example: Aquatics, Bowling, Exercise, etc.):

**I hereby give my approval for the above named person to engage in, the
Therapeutic Recreation program conducted by the Norfolk Department of
Neighborhood and Leisure Services, Therapeutic Recreation Center.**

Date _____

Physician's Signature

Telephone Number

**I have read and understand this form and agree to adhere to any and all of the
specific precautions recommended by the physician. I further agree that should
the physical conditions or medication of the aforementioned individual change in
any way I will immediately notify the Therapeutic Recreation Center of the Norfolk
Department of Neighborhood and Leisure Services.**

Date _____

Participant/Parent/Guardian Signature

MAIL TO: **Therapeutic Recreation Center**
 180 East Evans Street
 Norfolk, VA 23503
 (757) 441-1764

OR

OR FAX TO: (757) 441-1770